Supreme Court, U.S.
FILED
MAY 27 1999
CLERK

No. 98-1041

In the Supreme Court of the United States

GERALD WHITBURN, SECRETARY, WISCONSIN DEPARTMENT OF HEALTH AND FAMILY SERVICES, ET AL., PETITIONERS

v.

PATRICK ADDIS, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

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QUESTION PRESENTED

Whether Wisconsin's method of determining benefit eligibility and need levels for a class of Medicaid applicants is consistent with the requirement of 42 U.S.C. 1396a(a)(17)(D) that such methods not "take into account the financial responsibility" for the applicant of any other person except a parent or spouse.

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BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

This brief is submitted in response to the Court's order inviting the Solicitor General to express the views of the United States.

STATEMENT

1. The Medicaid Act, 42 U.S.C. 1396 *et seq.*, establishes a cooperative program under which the federal government provides matching funds to assist participating States in providing, among other things, medical assistance for families with dependent children "whose income and resources are insufficient to meet the costs of necessary medical services." 42 U.S.C. 1396. The Act is administered at the federal level by the Secretary of Health and Human Services, who disburses

matching funds to States with approved plans for providing medical assistance. See generally 42 U.S.C. 1301(a)(6), 1302(a), 1396, 1396b (1994 & Supp. III 1997). Although participation in the program is voluntary, and state plans may vary considerably in detail, participating States must comply with a number of requirements imposed by the Act and the Secretary's regulations. See 42 U.S.C. 1396a (1994 & Supp. III 1997); *Wilder* v. *Virginia Hosp. Ass'n*, 496 U.S. 498, 502 (1990); *Atkins* v. *Rivera*, 477 U.S. 154, 157 (1986).

The Act requires state Medicaid plans to include "reasonable standards * * * for determining eligibility for and the extent of medical assistance under the plan." 42 U.S.C. 1396a(a)(17). Those standards must "provide for taking into account only such income and resources as are * * * available to the applicant or recipient," and must not "take into account the financial responsibility of any individual for any applicant or recipient of assistance * * * unless such applicant or recipient is such individual's spouse or * * * [minor] child." 42 U.S.C. 1396a(a)(17)(B) and (D). The Act thus precludes participating States from assuming, either for purposes of ascertaining threshold eligibility or for purposes of setting benefit levels, that anyone other than a spouse or parent is contributing financially to the support of an applicant for Medicaid benefits. See also 42 C.F.R. 435.602(a)(1).

2. Some people become eligible for Medicaid benefits automatically after they qualify for benefits under another federal or federally supported program, such as Supplemental Security Income. See 42 U.S.C. 1396a(a)(10)(A)(i)(I)-(II). Other forms of eligibility depend on an assessment of the applicant's financial need, measured against standards prescribed by the States under general rules set by the Medicaid Act and

other federal law. See 42 U.S.C. 1396a(a)(10)(A)(i)(III)-(VII) and (a)(10)(A)(ii), 1396d(a); see also Pet. App. A5-A6; 58 Fed. Reg. 4908-4909, 4915 (1993). In performing such assessments for purposes of its Medicaid plan, Wisconsin first determines the income and assets that are deemed to be available to the applicant under plan rules, and then compares those amounts to applicable standards of need. See Pet. App. A7-A8, A23-A24.

In the first step of the process (determining income and assets), the State takes into account only the applicant's own income, plus a share of the income of any financially responsible spouse or parent.[1] The share of a spouse or parent's income to be allocated to the applicant is determined by dividing that income by the total number of people for whom the spouse or parent is financially responsible, including himself or herself. If, for example, the applicant is a child living with both parents and one sibling, any income that the sibling may have (from, for instance, disability benefits or child support payments) will be ignored, in compliance with 42 U.S.C. 1396a(a)(17)(D). The sibling's presence in the household will be taken into account, however, in attributing the parents' income, because each parent is recognized as financially responsible both for the other parent and for both children. Thus, if one parent earns $600 each month and the other $400, one-fourth of each amount will be attributed to each member of the household. If the applicant child has no independent income, his or her income for Medicaid eligibility purposes will be $250. Respondents do not

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[1] Although the Act requires assessment of both income and assets, in the interest of simplicity we focus on the determination of income for purposes of this brief.

challenge this aspect of Wisconsin's procedure. See Br. in Opp. 3.

Having determined the income attributable to a Medicaid applicant, the State next compares that income to an applicable standard of need. In many circumstances, including those relevant here, the Act requires the State, subject to the important exception assertedly applicable in this case, to use need standards (as well as methods of determining income) based on those it used under the former program of Aid to Families with Dependent Children (AFDC). See 42 U.S.C. 1396a(a)(10)(A)(i)-(ii), (C)(i)(III) and (*l*)(3)(E) (1994 & Supp. III 1997), 1396b(f) (1994 & Supp. III 1997), 1396u-1(a) and (b) (Supp. III 1997); 42 C.F.R. 435.601(a) and (b).[2] The Medicaid standards, like those under AFDC, generally treat each family as a unit, and vary according to family size. See generally, *e.g.*, 42 U.S.C. 602(a)(7)-(8), (31) and (38) (1994) (repealed); see also 42 U.S.C. 1396b(f)(1)(B) and (f)(3). Those standards are, moreover, established on the premise that there are economies inherent in group living, so that,

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[2] The AFDC program was replaced in 1996 by a new program, Temporary Assistance for Needy Families. Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Pub. L. No. 104-193, Tit. I, 110 Stat. 2110 (enacting provisions codified at 42 U.S.C. 601 *et seq.* (Supp. III 1997)); see *Saenz* v. *Roe*, No. 98-97 (May 17, 1999), slip op. 4. PRWORA simultaneously amended the Medicaid Act, however, to provide that, subject to qualifications not at issue here, statutory and other references in or under the Medicaid Act, including those involving "income and resource standards and income and resource methodologies," continue to refer to the former AFDC provisions and the various state plans implemented under them, "as in effect as of July 16, 1996, with respect to [each] State." 42 U.S.C. 1396u-1(a) (Supp. III 1997), enacted by PRWORA § 114(a)(2), 110 Stat. 2177.

for example, the need standard for a family of two is less than twice the standard for a family of one, and one-third the standard for a family of three is less than one-half the standard for a family of two. See Pet. App. A31, A33; compare *Bowen* v. *Gilliard*, 483 U.S. 587, 599 (1987).

To make need determinations for individual Medicaid applicants, Wisconsin compares the individual income levels it has calculated for the applicant to an individual need standard that it computes by prorating the need standard for a family the size of the applicant's entire family (limited to those family members who live together in the same household), including family members whose incomes were not counted in determining the income and resources attributable to the applicant. Thus, in the example given above, the State would use the need standard for a family of four, even though no income belonging to the applicant's sibling was included in computing the applicant's income. If the State set its need standard for a family of four at $360, the individual need standard would be $90, and the child in the example would not be eligible for Medicaid assistance, because his or her income was determined to be $250 for Medicaid purposes.[3]

3. Petitioners are the Secretary of the Wisconsin Department of Health and Family Services and other state officials responsible for the administration of Wisconsin's Medicaid program. Respondents sued petitioners in federal district court, purporting to represent

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[3] In some cases, the child would become eligible if an amount equal to the excess of attributed income ($250) over individual need ($90) had been spent on medical care, health insurance, or certain other allowable expenses. See Pet. App. A24; Wis. Stat. Ann. § 49.47(4)(c)(2) (West Supp. 1998).

(among others) a class of actual or potential Medicaid beneficiaries. Respondents sought declaratory and injunctive relief on the ground that Wisconsin's method of computing applicable individual need standards takes into account the financial responsibility for the applicant of family members other than the applicant's spouse or parents, in violation of 42 U.S.C. 1396a(a)(17)(D).[4]

The district court rejected respondents' challenge to the State's method of calculating need. Pet. App. A19-A37. After reviewing the law governing the federal and state programs (*id.* at A19-A25), the court noted that responsibility for the operation of Medicaid programs is committed largely to the States, and that the state methodology at issue is one that the Secretary once proposed to mandate through federal regulations (*id.* at A26-A27). The court then rejected any general challenge to the State's method of calculating income on the basis of proration within units consisting of an applicant and his or her spouse and parents, holding that the State's procedure reflects a reasonable implementation of applicable federal rules. *Id.* at A28-A30. The court also rejected respondents' specific claim that the use of need standards based on the total number of family members living in the household, including members whose income may not be counted as available

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[4] Respondents also challenged the State's rules for determining the satisfaction of Medicaid "deductible[s]," and its rules for determining Medicaid eligibility when a disabled individual applies for benefits both for himself or herself and for a child or children in his or her care. See Pet. App. A8; Br. in Opp. 3. The court of appeals struck down the deductible rules (Pet. App. A16), but sustained the State's treatment of applications by disabled caretakers (*id.* at A16-A18). Neither of those rulings has been challenged in this Court. See Pet. 3.

to the applicant under Section 1396a(a)(17)(D), violates that Section. Observing that the provision in question prohibits taking into account "the *financial responsibility*" for the applicant of any individual other than a parent or spouse (*id.* at A31), the court reasoned that "[t]he assumption that an individual's need is less because he lives in a household with multiple members is not the equivalent" of deeming every member's income to be available to the applicant, but rather merely "reflects a common-sense judgment that living expenses are higher for individuals maintaining their own independent households than they are for individuals sharing accommodations." *Id.* at A32; see *id.* at A32-A33. The court accordingly granted petitioners' motion to dismiss respondents' complaint. *Id.* at A37.

The court of appeals reversed in relevant part. Pet. App. A1-A18. The court agreed with respondents that the State's use of a need standard based on total family size, by "assum[ing] that the applicant's need is less because of the presence of non-legally responsible persons in the household," has "the same effect as deeming the income of those nonlegally responsible relatives to [be available to] the applicant," and on that basis the court held that that approach to assessing need violates Section 1396a(a)(17)(D). *Id.* at A11-A12. Noting that "it is the need standard employed by the state that ultimately will determine both the applicant's eligibility for medical assistance * * * [and] the amount of benefits that will be available," the court observed that "when a state assumes that an applicant's living expenses are less based solely upon the presence of non-legally responsible persons in the household, thereby reducing the applicant's level of need," it "necessarily is assuming that those persons

will be contributing to the applicant's living expenses." *Id.* at A13.

The court rejected the argument that Wisconsin's procedure merely takes account of "economies of scale." Pet. App. A13. It reasoned that any computation of need "premised on the assumption that contributions from members of the household [who] are not financially responsible for the applicant are nonetheless *actually* benefitting the applicant by reducing the amount of income/resources that applicant needs for non-medical essentials" amounts, in effect, to "the taking into account of the 'financial responsibility' of that non-responsible individual." *Ibid.* A13. The court concluded:

> [B]y prorating the applicant's need based upon the need standard for the applicant's entire family group, including individuals * * * who are not legally responsible for the applicant, Wisconsin is violating subsection (17)(D) in that it is implicitly considering the financial responsibility for the applicant of a non-legally responsible person in the household.

Id. at A15-A16. The court of appeals accordingly reversed the district court's dismissal of respondents' complaint, and remanded the case to that court for further proceedings. *Id.* at A18.

DISCUSSION

The court of appeals in this case adopted one plausible interpretation of the relevant provisions of the Medicaid Act. While the alternative construction advanced by petitioner is not unreasonable, it has not been adopted by any court of appeals, and previous federal regulations based on that construction were

withdrawn before they became effective. In the absence of any conflict on the issue among the courts of appeals, or between the courts and the Secretary, the decision below does not warrant review by this Court.

1. As we have explained (see pp. 2-5, *supra*), some individuals or families are eligible for Medicaid benefits only if their income and assets fall below threshold amounts. In many cases the Medicaid Act requires, subject to the important exception at issue in this case, that each State determine Medicaid eligibility using the methods for determining income, and the threshold need standards, that the State used for purposes of the former AFDC program. See p. 4 & note 2, *supra*.

The statutory question presented in this case arises because, beginning in 1984, Congress required that computations of income and need for AFDC purposes be made on a combined basis for defined family groups —including, for example, all eligible siblings living in the same household. See 42 U.S.C. 602(a)(38) (1994) (repealed); *Bowen* v. *Gilliard*, 483 U.S. 587, 592-594 (1987). A number of courts thereafter held, however, that States could not apply the new AFDC grouping requirements in assessing income for purposes of Medicaid eligibility, if doing so would—as in the case of siblings—violate the proscription in 42 U.S.C. 1396a(a)(17)(D) against "tak[ing] into account the financial responsibility of any individual [other than a spouse or parent] for any applicant or recipient of [Medicaid] assistance." See, *e.g.*, *Malloy* v. *Eichler*, 860 F.2d 1179, 1182 (3d Cir. 1988); *Georgia Dep't of Med. Assistance* v. *Bowen*, 846 F.2d 708, 710 (11th Cir. 1988); see also 42 U.S.C. 1396a(*l*)(3)(E) (providing that, for certain groups of Medicaid applicants, family income "shall be determined" using the State's AFDC methodology, "except to the extent such methodology is

inconsistent with clause (D) of subsection (a)(17)"). Those decisions, in which the Secretary ultimately acquiesced, left state Medicaid administrators without definitive guidance concerning what modifications to AFDC income-determination and need-determination methods were required or permitted before those methods were used for determining eligibility for Medicaid. See 59 Fed. Reg. 43,051 (1994) (describing issue); 54 Fed. Reg. 39,427-39,428 (1989) (same); see also 58 Fed. Reg. 4924 (1993) ("States only know that they cannot use AFDC standard filing unit policy, but do not know what to use instead.").

The Secretary initially sought to address that uncertainty in commentary accompanying the publication, in 1989, of proposed regulations specifically addressing a number of other issues under the Act. 54 Fed. Reg. at 39,426-39,428. The commentary identified and discussed the issue, and proposed the adoption of a nationwide policy: No one but a spouse or parent would be automatically grouped with a Medicaid applicant for purposes of determining eligibility, but all family members in a household who applied for Medicaid benefits would be treated as a single group under the AFDC rules. *Ibid.* The commentary specifically noted, however, that there were other possible approaches, and the Secretary invited comments from all interested parties concerning how best to reconcile the Act's requirements that States make eligibility determinations based on AFDC standards, but at the same time attribute financial responsibility only to parents and spouses. *Id.* at 39,428.

The Secretary's invitation drew a mixed response. Some commenters supported the Secretary's proposal, while others argued that treating relatives other than spouses and parents as part of one family unit would

violate Section 1396a(a)(17)(D), even if the family were allowed the option (not available under AFDC) of excluding such relatives from the eligibility computations by not applying for Medicaid benefits on their behalf. See 58 Fed. Reg. at 4916. That argument was also made in litigation. In 1990, a federal district court enjoined the State of California from enforcing eligibility rules that were consistent with the Secretary's initial proposal, and enjoined the Secretary from requiring or permitting the use of such rules by any State within the Ninth Circuit. *Sneede* v. *Kizer*, 728 F. Supp. 607 (N.D. Cal. 1990) (enjoining enforcement of California rules); *Sneede* v. *Kizer*, No. C89-1932-TEH, 1990 WL 155532 (N.D. Cal. May 3, 1990) (certifying circuit-wide class to challenge Secretary's policy); see *Sneede* v. *Coye*, 856 F. Supp. 526, 530 (N.D. Cal. 1994) (noting that initial injunction was later extended to cover federal defendants).

In attempting to frame a remedial decree responsive to the district court's initial decision in *Sneede*, the Secretary joined California officials in proposing a revised system for determining Medicaid eligibility in that case. See *Sneede* v. *Kizer*, No. C89-1932-TEH, 1990 WL 155532 (N.D. Cal. June 8, 1990) (addressing dispute over how to comply with initial decision), aff'd mem., 951 F.2d 360 and 362 (9th Cir. 1990), cert. denied, 506 U.S. 939 (1992). Under that proposal, Medicaid applicants' income would have been computed on the basis of family groups that included only children, parents, and spouses whose financial responsibility for each other could properly be taken into account under Section 1396a(a)(17)(D). The resources so determined would then have been compared, however, to individual need standards derived by ascertaining the size of the family group that would have been used for AFDC purposes

(which would typically be larger than the special Medicaid family group), and then dividing the AFDC need standard for a family of that size by the total number of members in the AFDC group. See *Sneede*, 1990 WL 155532, at *4. The method for determining eligibility proposed by the Secretary in *Sneede* was thus essentially the same as the Wisconsin method at issue in this case.

The district court in *Sneede* rejected the use of that method, holding that Section 1396a(a)(17)(D) prohibits taking the presence of a non-financially-responsible member of a Medicaid applicant's household into account in determining the applicable need standard, just as it prohibits taking such a member's income into account in determining the financial resources available to the applicant. *Sneede*, 1990 WL 155532, at *5-*7. The Ninth Circuit affirmed that decision in an unpublished (and hence non-precedential, see 9th Cir. R. 36.3) opinion. *Sneede* v. *Kizer*, No. 90-15141, 1991 WL 268830 (9th Cir. Dec. 13, 1991) (decision noted at 951 F.2d 362 (Table)), cert. denied, 506 U.S. 939 (1992).

After further analysis, and in light of those developments, the Secretary ultimately abandoned the particular nationwide policy that had been proposed in the 1989 regulatory commentary. Instead, in early 1993, the Secretary adopted, subject to public comment and a deferred effective date, final regulations that would have required States outside the Ninth Circuit (where the *Sneede* injunction remained in effect) to adopt and apply essentially the same methodology that had been proposed (and rejected by the courts) in *Sneede*. See 58 Fed. Reg. at 4908, 4915-4917, 4923-4924, 4930-4931 (§§ 435.602(d), 435.604 and 435.606). The commentary accompanying publication of the new regulations recognized that the approach adopted "[might] not be

ideal," but it characterized that approach as the drafters' "best attempt to harmonize the competing demands of the various provisions of the Medicaid statute[,] as interpreted by most of the courts[,] * * * in a manner consistent with simplicity of administration." 58 Fed. Reg. at 4916.

The 1993 regulations addressing this issue were given a delayed effective date to allow an opportunity for public comment, and that date was later extended twice in order to allow for further review. See 58 Fed. Reg. at 4916, 4924; 59 Fed. Reg. at 43,051. Describing the comments she received on this issue, the Secretary explained that, with one exception, the 13 States and seven interest groups that submitted comments all objected to the methodology the regulations would require for determining eligibility, characterizing it as "error prone," "unnecessarily complex," and likely to result in "significant administrative costs." 59 Fed. Reg. at 43,051. A technical advisory group consulted by the Secretary also expressed a preference for a policy that would "minimize[] the disruption of current approaches"; and advocates for benefit recipients "endorse[d] allowing States a choice of several options, but strongly oppose[d] allowing the budgeting method in the * * * regulation to be one of [those] options." *Ibid.*

In light of those comments, the Secretary ultimately decided not to include in her regulations any one federal policy on how to adapt the rules and methods then applicable under AFDC for purposes of determining Medicaid eligibility. She instead withdrew the 1993 regulations on the issue, which had never become effective, in favor of "allowing States flexibility, within any constraints imposed by court orders or agreements with recipient advocate groups, to interpret the current

provisions" of federal law. 59 Fed. Reg. at 43,052. As the Secretary explained, "in the absence of specific regulatory guidance on the methodologies for establishing income and resource eligibility" for affected Medicaid applicants, the States would merely be "required to use methodologies that comply with the statute and any applicable court orders." *Ibid.*

2. The textual question ultimately at issue in this case is a narrow and rather subtle one: Whether using a need standard that takes account of certain economies of scale that are generally involved in group living amounts to "tak[ing] into account the financial responsibility" of one household member for another, within the meaning of Section 1396a(a)(17)(D). The court of appeals adopted one permissible answer to that question, holding that the use of such a standard does violate Section 1396a(a)(17)(D).

Section 1396a(a)(17) governs the determination of both "eligibility for and the extent of medical assistance" under the Act. The reference to the "extent" of assistance may be read to suggest that the prohibition in clause (D) should apply not only to determining the income attributable to an applicant, but also to determinations that involve comparing that income to a need standard, especially where that comparison establishes an amount of medical or similar expenses the applicant must incur before becoming eligible for Medicaid. See note 3, *supra*. In addition, it is possible to read "financial responsibility" more broadly than did the district court in this case (see *id.* at A31-A32), to encompass "the assumption that contributions from members of the household [who] are not financially responsible for the applicant are nonetheless *actually* benefitting the applicant by reducing the amount of income/resources that [the] applicant needs [or that others, such as the

applicant's parents, must expend on the applicant's behalf] for non-medical essentials." *Id.* at A13 (quoting *Sneede*, 1990 WL 155532, at *6). There may also be a question whether it is appropriate, as a policy matter, to import into a medical assistance program, without any modification, family-size-based need standards that were designed to reflect the sort of "economies of scale" that commonly apply to expenses such as housing, utilities, and to some extent food.[5] Finally, the decision below is consistent with the line of appellate cases holding that Section 1396a(a)(17)(D) requires modification of the family units used to determine an applicant's *income* under AFDC, and with the decision of the only other court of appeals to have addressed, albeit in a non-precedential opinion, the precise question presented by this case. See *Malloy*, and cases there cited; *Sneede*, 1991 WL 268830.

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[5] In the context of a general economic assistance program it makes sense to take account of the fact that a family of three may not pay any more for housing or electricity, and not much more for food, than a family of two. It is not, however, obvious that it will generally cost a mother less to buy medical care for a second child, simply because she already has to buy care for the first. Patients do not typically realize significant "economies of scale" on expenses for medical essentials such as doctor visits, vaccinations, or eyeglasses. At the same time, the ascertainment of need under the Medicaid program also takes account of family expenses other than those for medical care, and for those expenses economies of scale presumably are present. Thus, although it is true that the decision below treats income and need determinations differently in limited respects (see Pet. 7), it is also true that in the Medicaid context there are at least some grounds on which it may be sensible to do so. It is realistic to assume that a parent's resources will be stretched evenly over herself, her spouse, and all of her dependents. It is not necessarily realistic to expect that all her financial needs, or those of her children, can be as easily prorated.

That the decision below rests on a permissible interpretation of Section 1396a(a)(17)(D) does not require the contrary conclusion concerning the different interpretation of that provision advanced by petitioner. As the district court explained in this case, it is also possible to read the statutory phrase "financial *responsibility*" to refer to an obligation to contribute available income or assets to the common good, without reference to the distinct question of an applicant's financial *need*. Pet. App. A31-A32 (emphasis altered). Moreover, as petitioner points out (Pet. 7), the court of appeals' construction of Section 1396a(a)(17)(D) may result in seeming inconsistencies between the required determinations of income and need.[6] Indeed, as we have described, the Secretary previously advocated adoption of an eligibility-determination method similar to Wisconsin's, both in the *Sneede* litigation and in the 1993 regulations. See also 54 Fed. Reg. at 39,427-39,428; *Sneede*, 1991 WL 268830, at **2-**3 (describing arguments advanced by the State and the Secretary in that case).

The existence of reasonable textual and policy arguments on both sides of the issue has consistently led the Secretary to acknowledge that the question presented in this case is a difficult one, to which there may be a

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[6] All agree, for example, that if a single mother lives with her three children, one-fourth of the mother's income is properly attributed to each child, even if the Medicaid application unit in question excludes one of the children (perhaps because he has independent income, which may not properly be attributed to his siblings). Although the "excluded" child is therefore taken into account in ascertaining the income deemed available to the application unit, under the decision below the existence of the same child must be ignored when it comes to ascertaining the unit's financial need.

number of plausible answers. See 54 Fed. Reg. at 39,428 (noting existence of alternatives and soliciting comments); 58 Fed. Reg. at 4916 (recognizing difficulty of problem and characterizing new regulation as a "best attempt"); see also Pet. App. A30-A33 (district court's opinion sustaining State's position in this case); cf. *Sneede*, 1991 WL 268830, at **4 (declining to award attorneys' fees because position advanced by State and Secretary in that case "had a reasonable basis in law and fact"). Such situations are not uncommon in the administration of complex national benefit programs, and are often resolved through the adoption, by federal administrators, of a formal interpretation of the relevant law. In this case, the Secretary could reasonably have issued regulations adopting either petitioners' or respondents' construction of the Medicaid Act, and that determination would have been not only permissible, but authoritative. See, *e.g.*, *Your Home Visiting Nurse Servs., Inc.* v. *Shalala*, 119 S. Ct. 930, 933-934 (1999); *Atkins* v. *Rivera*, 477 U.S. 154, 162 (1986); *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837, 844 (1984); *Schweiker* v. *Gray Panthers*, 453 U.S. 34, 43-44 (1981).[7]

In this unusual instance, however, the Secretary, after thorough consideration, decided not to promulgate regulations adopting any definitive interpretation of

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[7] The Ninth Circuit was accordingly wrong to suggest, in its memorandum opinion in *Sneede*, that the terms of the Medicaid Act compelled the result it reached, regardless of the Secretary's construction of the Act. See 1991 WL 268830, at **2-**3; compare *Gray Panthers*, 453 U.S. at 43 ("The Social Security Act is among the most intricate ever drafted by Congress," and Congress has therefore "conferred on the Secretary exceptionally broad authority to prescribe standards for applying certain sections of the Act," including 42 U.S.C. 1396a(a)(17)(B).).

the relevant statutory provisions or to impose any one methodology on the States. She determined that it would instead be preferable, under all the circumstances, to allow States participating in the Medicaid program the greatest possible flexibility to apply those provisions, in light of their own state plans, administrative structures, resource constraints, and policy priorities. See 59 Fed. Reg. at 43,052. In her announcement of that determination, however, the Secretary made clear that the resulting freedom to adopt different methods for determining Medicaid eligibility would remain subject to each State's ultimate responsibility to "comply with the statute and [with] any applicable court orders." *Ibid.* Respondents brought the present case on the theory that Wisconsin's method of determining Medicaid eligibility does *not* "comply with the statute."

Federal courts have a general obligation to adjudicate federal claims properly before them; and, in the absence of any authoritative interpretation by the Secretary, it was proper for both courts that considered this case to identify and construe for themselves the relevant provisions of federal law. As we have explained, the construction urged by respondents and adopted by the court of appeals is a permissible one. The court's decision does not conflict with any decision of this Court or of any other court of appeals, or with any construction presently adopted by the Secretary.[8]

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[8] In addition, the likely practical impact of the decision is obscured by Wisconsin's impending implementation (in July 1999) of a "child health plan" approved under the State Children's Health Insurance Program, 42 U.S.C. 1397aa *et seq.* (Supp. III 1997), which makes additional federal funds available to participating States to help fund health care for low-income children who do not qualify for Medicaid benefits. See generally 42 U.S.C. 1397aa(a)

Under these circumstances, the question presented by the State's petition for a writ of certiorari does not warrant review by this Court.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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MAY 1999

(purpose), 1397bb(3)(A)-(B) (eligibility screening and coordination with Medicaid), 1397dd(d) (coordination with Medicaid), 1397jj(b) (defining "targeted low-income child" as one with family income below specified Medicaid eligibility levels, and not otherwise eligible for Medicaid) (Supp. III 1997).